

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

January 10, 2012
January 19, 2012 – Amended
January 19, 2012 – Amended 2

DATE OF REVIEW: January 19, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT of the Lumbar Spine without and with Dye, Self-Management Education and Training, 1 PT and Office/Outpatient Visit, Established. CPT Codes: 72133, 98960 and 99215.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE, AMERICAN ACADEMY OF PAIN MANAGEMENT

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY:

The description of services in dispute includes the medical necessity for a CT scan of the lumbar spine with and without dye.

The review outcome is to uphold the previous non-authorization.

The Guidelines references used include the Official Disability Guidelines (ODG), Treatment Index, 9th Edition, Webb 2011, under indications for Imaging – Computed Tomography.

This is a male who sustained a work-related injury on xx/xx/xx, involving the lumbar spine. Subsequent to the injury, the patient has a working diagnosis of failed back surgery syndrome. The patient continues with daily low back pain that radiates down the left lower extremity. The notes indicate the patient has a lumbar spinal cord stimulator, which was repositioned as of July 29, 2011.

The current medication management consists of a long-acting opioid and muscle relaxants. From the last note submitted by the treating physician dated September 1, 2011, the patient has 90% improvement with the medications which allow him to stay active and to perform activities of daily living. The clinical examination of the lumbar spine revealed no motor/reflex and/or sensation deficits. The range of motion of the lumbar spine was recorded as normal.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.

After review of the information submitted, the previous non-authorization for request of a lumbar CT scan with and without contrast is to be upheld. The patient has a diagnosis of failed back surgery syndrome and chronic pain syndrome and experiences from chronic pain daily. However, from the clinical documentation submitted regarding the clinical examination, there were no new and/or progressive neurologic deficits to warrant performing a radiographic imaging study (i.e. CT scan). The ODG Guidelines clearly indicate that repeat radiographic imaging studies (i.e. MRI scans and/or CT scans) are only indicated if there has been a progression of neurologic deficit documented.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)